UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

SABRIL (vigabatrin)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO (801) 536-0477

CRITERIA:

- Minimum age requirement: 16 years old.
- Documented failure of other therapy.
- Uncontrolled complex partial seizures.
- Documented enrollment of both prescriber and patient in the SHARE program.
- Negative pregnancy test for women of childbearing age.

AUTHORIZATION:

The initial prior authorization will be approved for six months to assess safety and efficacy in the individual patient.

RE-AUTHORIZATION:

Subsequent prior authorizations will be given in one year increments, and require documentation of ongoing vision testing every three months while on therapy.